KENTUCKY BOARD OF PHARMACY
SPINDLETOP ADMINISTRATION BLDG., STE 302
2624 RESEARCH PARK DRIVE
LEXINGTON, KY 40511
PHONE 859-246-2820
FAX 859-246-2823

APPLICATION FOR PHARMACY PERMIT RENEWAL

Enclose a check or money order for $100.00, made payable to 'Kentucky State Treasurer'. Please print legibly and complete both sides of this application; including the required original signatures and return in duplicate [for Kentucky resident facilities only] no later than June 30th.
For non-resident permit holders, please provide a copy of your resident state permit and a copy of your last inspection report.

Pharmacy Name _____ Permit No. _____

Address _____

_____

_____

Telephone No. _____ Fax No. _____

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED.

DEA Registration No._____ Expiration Date:_____

Date of last controlled substance inventory:_____

Ownership:

❒ Sole Proprietor ❒ Partnership ❒ Corporation ❒ LLC ❒ Other

Name and title for each owner/officer, including office and professional designation:

_____
_____
_____

Pharmacist-In-Charge(PIC) and Registered Pharmacist(s):

	Name	KY License No.	POA	Key
PIC:	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____

[Please indicate by checking the space provided those who have "Power of Attorney" (POA) to order controlled substances and those who have keys to the pharmacy.]
Note: 201 KAR 2:205 requires the pharmacist-in-charge to notify the Board within fourteen [14] calendar days of all pharmacist changes.

Name, title and address of each non-pharmacist with keys to the pharmacy:

_____

_____

Schedule of hours*:

Monday	_____ AM to _____ PM	Friday	_____ AM to _____ PM
Tuesday	_____ AM to _____ PM	Saturday	_____ AM to _____ PM
Wednesday	_____ AM to _____ PM	Sunday	_____ AM to _____ PM
Thursday	_____ AM to _____ PM	**Please indicate if closed for lunch.**	_____

*P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.

Name, address and affiliation of all individuals, other than those previously identified in this application, responsible for pharmacy operations, management or staffing (eg. Pharmacy Services Management companies or consultants):

_____

_____

_____

Does pharmacy currently utilize an automated data processing system? Yes _____ No _____

If yes, identify the hardware _____ software_____

Type of Pharmacy (Indicate by circling all that apply):

Retail Independent	Retail Chain	Hospital	Nursing Home	Nuclear
Internet	Mail Order	Infusion	Out-of-State	Oxygen

The Board may refuse to issue or renew a permit, or suspend, temporarily suspend, revoke, fine or reasonably restrict any permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit. KRS 315.121.

I hereby certify that the foregoing is true and correct to the best of my knowledge, that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the Regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws. [If applicable, this pharmacy is currently licensed and in good standing in all states of licensure.]

_____ _____

(Signature of Pharmacist-in-Charge) (Signature of Owner)

_____ _____

(Date) (Date)